NAME OF THE HOSPITAL: _____

1. Photocoagulation for Retinopathy of Prematurity: S3B10.1

1. Name of the Procedure: Photocoagulation for Retinopathy of Prematurity

2. Indication: Type 1 Pre-threshold ROP

3. Does the patient presented with Type 1 Pre-threshold Retinopathy of Prematurity diagnosed on Fundus Examination: Yes/No (Upload Fundus Photograph/ Fundus Sketch)

4. If the answer to question 3 is Yes then is the patient having evidence of Media Opacities resulting in poor view of fundus: Yes/No

For eligibility for Photocoagulation for Retinopathy of Prematurity, the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

2. Pediatric Cataract Surgery – Phacoemulsification - IOL: Bilateral/Unilateral Congenital Cataract: S3B10.2

1. Name of the Procedure: Pediatric Cataract Surgery – Phacoemulsification - IOL

2. Select the Indication from the drop down of various indications provided under this head:

Bilateral/Unilateral congenital cataract
Traumatic cataract

3. Does the patient presented with Unilateral/Bilateral congenital cataract: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-scan, A-scan and TORCH titres for congenital cataract done: Yes/No (Upload Reports)

5. If the answer to question 4 is Yes then is there evidence of:
   a. Severe Microphthalmia (Corneal diameter less than 5 mm): Yes/No
   b. Irreparably detached retina: Yes/No

For eligibility for Pediatric Cataract Surgery – Phacoemulsification - IOL, the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

3. Pediatric Cataract Surgery – Phacoemulsification - IOL: Traumatic Cataract: S3B10.2

1. Name of the Procedure: Pediatric Cataract Surgery – Phacoemulsification - IOL

2. Select the Indication from the drop down of various indications provided under this head:

Bilateral/Unilateral congenital cataract
Traumatic cataract

3. Does the patient presented with Traumatic Cataract: Yes/No (Upload Clinical photograph, previous operative notes if it was an open globe injury)

4. If the answer to question 3 is Yes then is the B-scan and A-scan done: Yes/No (Upload Reports)

5. If the answer to question 4 is Yes then is there evidence of:
   a. Severe Microphthalmia (Corneal diameter less than 5 mm): Yes/No
   b. Irreparably detached Retina: Yes/No

For eligibility for Pediatric Cataract Surgery – Phacoemulsification - IOL, the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

4. Glaucoma Filtering Surgery for Pediatric Glaucoma: IOP not controlled despite maximal medical therapy: S3B10.3

1. Name of the Procedure: Glaucoma Filtering Surgery for Pediatric Glaucoma

2. Select the Indication from the drop down of various indications provided under this head:

IOP not controlled despite maximal medical therapy
Congenital Glaucoma

3. Does the patient presented with signs and symptoms suggestive of raised IOP which is not controlled despite maximal medical therapy: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the OCT and Visual field charting done in co-operative and above 6 yrs old children: Yes/No (Optional Investigation)

6. If the answer to question 4 AND OR question 5 is Yes is there evidence of:
   a. Glaucomatous optic atrophy: Yes/No
   b. Acute congestive episode of Glaucoma: Yes/No

For eligibility for Glaucoma Filtering Surgery for Pediatric Glaucoma, the answer to questions 6a AND 6b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

5. Glaucoma Filtering Surgery for Pediatric Glaucoma: Congenital Glaucoma: S3B10.3

1. Name of the Procedure: Glaucoma Filtering Surgery for Pediatric Glaucoma

2. Select the Indication from the drop down of various indications provided under this head:

IOP not controlled despite maximal medical therapy
Congenital Glaucoma

3. Does the patient presented with signs suggestive of Congenital Glaucoma: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the OCT and Visual field charting done in co-operative and above 6 yrs old children: Yes/No (Optional Investigation)

6. If the answer to question 4 AND OR question 5 is Yes is there evidence of:
   a. Glaucomatous optic atrophy: Yes/No
   b. Acute congestive episode of Glaucoma: Yes/No

For eligibility for Glaucoma Filtering Surgery for Pediatric Glaucoma, the answer to questions 6a AND 6b should be No

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NAME OF THE HOSPITAL: _____

6. Scleral Buckle for Retinal Detachment: S3B11.1

1. Name of the Procedure: Scleral Buckle for Retinal Detachment

2. Indication: Retinal Detachment

3. Does the patient presented with shadow or curtain that affected any part of the vision: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the B-Scan done: Yes/No (Upload B-scan report)

6. If the answer to question 5 is Yes is there evidence of:
   a. Media opacity obscuring visualization like vitreous hemorrhage, vitreous debris: Yes/No
   b. Advanced proliferative vitreo retinopathy: Yes/No
   c. Posterior tears: Yes/No
   d. Giant Retinal tear: Yes/No

For eligibility for Scleral Buckle for Retinal Detachment, the answers to questions 6a AND 6b AND 6c AND 6d should be No

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NAME OF THE HOSPITAL: _____

7. Photocoagulation for Diabetic Retinopathy per Sitting: Clinically significant Macular edema: S3B11.2

1. Name of the Procedure: Photocoagulation for Diabetic Retinopathy

2. Select the Indication from the drop down of various indications provided under this head:

Clinically significant Macular edema
Proliferative Diabetic Retinopathy

3. Does the patient presented with blurred or wavy central vision and/or colors appear "washed out" or changed: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the OCT, B-Scan and FFA done: Yes/No (Upload investigation reports)

6. If the answer to question 5 is Yes is there evidence of:
   a. Vitreous Hemorrhage: Yes/No
   b. Media opacity like cataract, corneal opacity: Yes/No

For eligibility for Photocoagulation for Diabetic Retinopathy, the answer to questions 6a AND 6b should be No

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NAME OF THE HOSPITAL: _____

8. Photocoagulation for Diabetic Retinopathy per Sitting: Proliferative Diabetic Retinopathy: S3B11.2

1. Name of the Procedure: Photocoagulation for Diabetic Retinopathy

2. Select the Indication from the drop down of various indications provided under this head:

Clinically significant Macular edema
Proliferative Diabetic Retinopathy

3. Does the patient presented with Spots or dark strings floating in his vision (floaters)/ Blurred vision/ Fluctuating vision/ Dark or empty areas in vision/ Vision loss/ Difficulty with color perception: Yes/No

4. If the answer to question 3 is Yes then is the Fundus visualization done: Yes/No (Upload Fundus photograph/ Fundus sketch)

5. If the answer to question 4 is Yes then is the OCT, B-Scan and FFA done: Yes/No (Upload investigation reports)

6. If the answer to question 5 is Yes is there evidence of:
   a. Vitreous Hemorrhage: Yes/No
   b. Media opacity like cataract, corneal opacity: Yes/No

   For eligibility for Photocoagulation for Diabetic Retinopathy, the answer to questions 6a AND 6b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

9. Therapeutic Penetrating Keratoplasty: Perforated Corneal Ulcer: S3B5.1

1. Name of the Procedure: Therapeutic Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Perforated corneal ulcer
Non healing fungal/ bacterial/ viral/ mixed keratitis
Traumatic Corneal Perforation

3. Does the patient presented with Sudden drop in visual acuity/ Ocular pain/ Excess tear production: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of
   a. Phthisical or pre-phthisical eye: Yes/No
   b. Nasolacrimal duct blockage: Yes/No

For eligibility for Therapeutic Penetrating Keratoplasty, the answer to questions 5a & 5b should be No

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NAME OF THE HOSPITAL: _____

10. Therapeutic Penetrating Keratoplasty: Nonhealing fungal/bacterial/viral/mixed Keratitis: S3B5.1

1. Name of the Procedure: Therapeutic Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Perforated corneal ulcer
Non healing fungal/ bacterial/ viral/ mixed keratitis
Traumatic Corneal Perforation

3. Does the patient presented with pain/ impaired eyesight/ itchiness with findings of Non-healing keratitis on examination: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of
   a. Phthisical or pre-phthisical eye: Yes/No
   b. Nasolacrimal duct blockage: Yes/No

For eligibility for Therapeutic Penetrating Keratoplasty, the answer to questions 5a & 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

11. Therapeutic Penetrating Keratoplasty: Traumatic Corneal Perforation: S3B5.1

1. Name of the Procedure: Therapeutic Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Perforated corneal ulcer
Nonhealing fungal/ bacterial/ viral/ mixed keratitis
Traumatic Corneal Perforation

3. Does the patient presented with history of trauma to the eye and sudden drop in visual acuity/ Ocular pain/ Excess tear production: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of phthisical or pre-phthisical eye: Yes/No

For eligibility for Therapeutic Penetrating Keratoplasty, the answer to question 5 should be No

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NAME OF THE HOSPITAL: _____

12. Lamellar Keratoplasty: Opacity of superficial one third upto anterior 95% of cornea: S3B5.2

1. Name of the Procedure: Lamellar Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Opacity of superficial one third upto anterior 95% of cornea
Marginal corneal thinning or infiltration
Chronic inflammatory disease (e.g., atopic kerato conjunctivitis)

3. Does the patient presented with corneal opacity with accompanying vision loss: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Full thickness corneal opacity: Yes/No
   b. Adherent Leucoma: Yes/No

For eligibility for Lamellar Keratoplasty, the answer's to question 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

13. Lamellar Keratoplasty: Marginal corneal thinning or infiltration: S3B5.2

1. Name of the Procedure: Lamellar Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Opacity of superficial one third up to anterior 95% of cornea
Marginal corneal thinning or infiltration
Chronic inflammatory disease (e.g., atopic kerato conjunctivitis)

3. Does the patient presented with signs of Marginal corneal thinning or infiltration on examination: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the indirect ophthalmoscopy done: Yes/No (Upload Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Full thickness corneal opacity: Yes/No
   b. Adherent Leucoma: Yes/No

For eligibility for Lamellar Keratoplasty, the answer's to question 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

14. Lamellar Keratoplasty: Chronic inflammatory disease (e.g., atopic kerato conjunctivitis): S3B5.2

1. Name of the Procedure: Lamellar Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Opacity of superficial one third up to anterior 95% of cornea
Marginal corneal thinning or infiltration
Chronic inflammatory disease (e.g., atopic keratoconjunctivitis)

3. Does the patient presented with poor vision and severe ocular itching with examination findings suggestive of kerato conjunctivitis: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Full thickness corneal opacity: Yes/No
   b. Adherent Leucoma: Yes/No

For eligibility for Lamellar Keratoplasty, the answer's to question 5a AND 5b should be No

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NAME OF THE HOSPITAL: _____

15. Corneal Patch Graft: Descemetocoele: S3B5.3

1. Name of the Procedure: Corneal Patch Graft

2. Select the Indication from the drop down of various indications provided under this head:

Descemetocoele
Peripheral corneal thinning/ perforation

3. Does the patient presented with descemetocoele which was confirmed on examination of the eye : Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is there evidence of large central defect where therapeutic is indicated: Yes/No

For eligibility for Corneal patch graft, the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

16. Corneal Patch Graft: Peripheral corneal thinning/ perforation: S3B5.3

1. Name of the Procedure: Corneal Patch Graft

2. Select the Indication from the drop down of various indications provided under this head:

Descemetocoele
Peripheral corneal thinning/ perforation

3. Does the patient presented with signs suggestive of Peripheral corneal thinning/ perforation on examination of the eye: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is there evidence of large central defect where therapeutic is indicated: Yes/No

For eligibility for Corneal patch graft, the answer to question 4 should be No

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NAME OF THE HOSPITAL: _____

17. Scleral Patch Graft: Scleral thinning: S3B5.4

1. Name of the Procedure: Scleral Patch Graft

2. Select the Indication from the drop down of various indications provided under this head:

Scleral thinning
Necrotising scleritis/ uveal exposure through thin sclera

3. Does the patient presented with on examination findings suggestive of Scleral thinning: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of extensive irreparable lesion: Yes/No

For eligibility for Scleral patch graft, the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

18. Scleral Patch Graft: Necrotising scleritis/ uveal exposure through thin sclera: S3B5.4

1. Name of the Procedure: Scleral Patch Graft

2. Select the Indication from the drop down of various indications provided under this head:

Scleral thinning
Necrotising scleritis/ uveal exposure through thin sclera

3. Does the patient on examination had signs suggestive of Necrotising scleritis/ uveal exposure through thin sclera: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of extensive irreparable lesion: Yes/No

For eligibility for Scleral patch graft, the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

19. Penetrating Keratoplasty: Corneal dystrophies and opacities impairing vision: S3B5.5

1. Name of the Procedure: Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Corneal dystrophies and opacities impairing vision
Pseudophakic bullous keratopathy
Keratoconus

3. Does the patient presented with impaired vision due to Corneal dystrophies and opacities: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of phthisic and pre-phthisic eye: Yes/No

For eligibility for Penetrating Keratoplasty, the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

20. Penetrating Keratoplasty: Pseudophakic bullous keratopathy: S3B5.5

1. Name of the Procedure: Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Corneal dystrophies and opacities impairing vision
Pseudophakic bullous keratopathy
Keratoconus

3. Does the patient presented with poor vision and discomfort or pain after cataract surgery: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of phthisic and pre-phthisic eye: Yes/No

For eligibility for Penetrating Keratoplasty, the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

21. Penetrating Keratoplasty: Keratoconus: S3B5.5

1. Name of the Procedure: Penetrating Keratoplasty

2. Select the Indication from the drop down of various indications provided under this head:

Corneal dystrophies and opacities impairing vision
Pseudophakic bullous keratopathy
Keratoconus

3. Does the patient presented with blurred vision, glare and halos at night, and the streaking of lights: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes then is the B-Scan done: Yes/No (Upload B-Scan Report)

5. If the answer to question 4 is Yes is there evidence of phthisic and pre-phthisic eye: Yes/No

For eligibility for Penetrating Keratoplasty, the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

22. Double Z Plasty: S3B5.6

1. Name of the Procedure: Double Z plasty

2. Indication: Epicanthus

3. Does the patient presented with Epicanthus confirmed on clinical examination: Yes/No (Upload Clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Hypertrophic scar: Yes/No

For eligibility for Double Z Plasty, the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

23. Amniotic Membrane Graft: Pterigium Excision: S3B5.7

1. Name of the Procedure: Amniotic Membrane Graft

2. Select the Indication from the drop down of various indications provided under this head:

Pterigium Excision
Limbal stem cell deficiency
Conjunctival Reconstruction
Acid or Alkali injuries
Symblepheron Excision

3. Does the patient have
   a. Recurrent Pterigium: Yes/No
      AND/OR
   b. Large Pterigium: Yes/No
      AND/OR
   c. Fleshy Pterigium: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c is Yes then is the patient having evidence of Pterigium documented by clinical photograph: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes then is the patient having history of Amniotic graft failure in the past: Yes/No

For eligibility for Amniotic membrane graft, the answer to question 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

24. Amniotic Membrane Graft: Limbal stem cell deficiency: S3B5.7

1. Name of the Procedure: Amniotic Membrane Graft

2. Select the Indication from the drop down of various indications provided under this head:

Pterigium Excision
Limbal stem cell deficiency
Conjunctival Reconstruction
Acid or Alkali injuries
Symblepheron Excision

3. Does the patient have signs and symptoms of limbal stem cell deficiency: (Upload Clinical Photograph)
   a. Decreased Vision: Yes/No
      AND/OR
   b. Photophobia: Yes/No
      AND/OR
   c. Tearing: Yes/No
      AND/OR
   d. Blepharospasm: Yes/No
      AND/OR
   e. Recurrent episodes of pain: Yes/No

4. If the answer to questions 3a OR 3b OR 3c OR 3d OR 3e is Yes then is the patient having evidence of limbal stem cell deficiency on Impression Cytology: Yes/No (Attach Impression Cytology report)

5. If the answer to question 4 is Yes then is the patient having history of:
   a. Amniotic graft failure in the past: Yes/No
   b. Complete Limbal stem cell deficiency: Yes/No

For eligibility for Amniotic membrane graft, the answer to 5a AND 5b must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

25. Amniotic Membrane Graft: Conjunctival Reconstruction: S3B5.7

1. Name of the Procedure: Amniotic Membrane Graft

2. Select the Indication from the drop down of various indications provided under this head:

Pterigium Excision
Limbal stem cell deficiency
Conjunctival Reconstruction
Acid or Alkali injuries
Symblepheron Excision

3. Does the patient have evidence of cicatricial diseases/ chemical injuries where conjunctiva is extensively damaged: Yes/No (Upload clinical photograph)

4. If the answer to question 3 is Yes then is the patient having history of Amniotic graft failure in the past: Yes/No

For eligibility for Amniotic membrane graft, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

26. Amniotic Membrane Graft: Acid or Alkali Injuries: S3B5.7

1. Name of the Procedure: Amniotic Membrane Graft

2. Select the Indication from the drop down of various indications provided under this head:

Pterigium Excision
Limbal stem cell deficiency
Conjunctival Reconstruction
Acid or Alkali injuries
Symblepheron Excision

3. Does the patient have evidence of acid or alkali Injuries resulting in extensive damage to conjunctiva/cornea: Yes/No (Upload clinical photograph)

4. If the answer to question 4 is Yes then is the patient having history of Amniotic graft failure in the past: Yes/No

For eligibility for Amniotic membrane graft, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

27. Amniotic Membrane Graft: Symblepheron Excision: S3B5.7

1. Name of the Procedure: Amniotic Membrane Graft

2. Select the Indication from the drop down of various indications provided under this head:

Pterigium Excision
Limbal stem cell deficiency
Conjunctival Reconstruction
Acid or Alkali injuries
Symblepheron Excision

3. Does the patient have
   a. Limitation of ocular motility: Yes/No
      AND/OR
   b. Diminution of vision in cases having corneal affection: Yes/No
      AND/OR
   c. Exposure keratitis: Yes/No
      AND/OR
   d. Ankyloblepheron: Yes/No

4. If the answer to either question 3a AND/OR 3b AND/OR 3c AND/OR 3d is Yes then is the patient having evidence of Symblepheron documented by clinical photograph: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes then is the patient having history of Amniotic graft failure in the past: Yes/No

For eligibility for Amniotic membrane graft, the answer to 5 must be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

28. Vitrectomy: Vitreous Hemorrhage: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with visual haze/ floaters/ cloudy vision/ photophobia and perception of shadows and cobwebs: Yes/No

4. If the answer to question 3 is Yes is there evidence of vitreous hemorrhage documented on B-scan: Yes/No (Upload B- Scan report)

5. If the answer to question 4 is Yes then is the vitreous hemorrhage documented on Fundus Examination: Yes/No (Upload Fundus sketch/ photograph)

6. If the answer to question 5 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy the answer to questions 6a AND 6b should be No (If duration is less than 3 months, vitrectomy would not be suggestive)

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

29. Vitrectomy: Macular hole: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with blurred and distorted central vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Macular hole documented on Fundus Examination and OCT Macula: Yes/No (Upload Fundus sketch/ photograph AND OCT Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No
   c. Grade IA & IV macular hole: Yes/No
   d. With posterior vitreous detachment: Yes/No

For eligibility for Vitrectomy the answer to questions 5a AND 5b AND 5c AND 5d should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

30. Vitrectomy: Retinal Detachment: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with shadow or curtain affecting any part of the vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Retinal Detachment documented on Fundus Examination and B Scan: Yes/No (Upload Fundus sketch/ photograph AND B Scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

31. Vitrectomy: Epiretinal Membrane: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with blurring or distortion of central vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Epiretinal Membrane documented on Fundus Examination and OCT: Yes/No (Upload Fundus sketch/ photograph AND OCT Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

32. Vitrectomy: Foreign body in Vitreous cavity: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with history of injury to the eye with retained foreign body: Yes/No

4. If the answer to question 3 is Yes is there evidence of Foreign body in Vitreous cavity documented on Fundus Examination and B Scan: Yes/No (Upload Fundus sketch/ photograph AND B Scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No
   c. Opaque Media: Yes/No

For eligibility for Vitrectomy the answer to questions 5a AND 5b AND 5c should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

33. Vitrectomy: Endopthalmitis: S3B6.1

1. Name of the Procedure: Vitrectomy

2. Select the Indication from the drop down of various indications provided under this head:

Vitreous hemorrhage
Macular hole
Retinal Detachment
Epiretinal Membrane
Foreign body in Vitreous cavity
Endophthalmitis

3. Does the patient presented with severe pain, loss of vision, and redness of the conjunctiva and the underlying episclera: Yes/No

4. If the answer to question 3 is Yes is there evidence of Endophthalmitis documented on Fundus Examination and B Scan: Yes/No (Upload Fundus sketch/ photograph AND B Scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

34. Vitrectomy + Membrane Peeling+ Endolaser: Epiretinal Membrane: S3B6.2

1. Name of the Procedure: Vitrectomy + Membrane Peeling+ Endolaser

2. Select the Indication from the drop down of various indications provided under this head:

Epiretinal Membrane
Vitreous hemorrhage
Tractional retinal detachment

3. Does the patient presented with blurring or distortion of central vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Epiretinal membrane documented on Fundus Examination and OCT: Yes/No (Upload Fundus sketch/ photograph AND OCT Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy + Membrane Peeling+ Endolaser the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

35. Vitrectomy + Membrane Peeling+ Endolaser: Vitreous Hemorrhage: S3B6.2

1. Name of the Procedure: Vitrectomy + Membrane Peeling+ Endolaser

2. Select the Indication from the drop down of various indications provided under this head:

Epiretinal Membrane
Vitreous hemorrhage
Tractional retinal detachment

3. Does the patient presented with visual haze/ floaters/ cloudy vision/ photophobia and perception of shadows and cobwebs: Yes/No

4. If the answer to question 3 is Yes is there evidence of Vitreous hemorrhage documented on Fundus Examination and B scan: Yes/No (Upload Fundus sketch/ photograph AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy + Membrane Peeling+ Endolaser the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

36. Vitrectomy + Membrane Peeling+ Endolaser: Tractional retinal detachment: S3B6.2

1. Name of the Procedure: Vitrectomy + Membrane Peeling+ Endolaser

2. Select the Indication from the drop down of various indications provided under this head:

Epiretinal Membrane
Vitreous hemorrhage
Tractional retinal detachment

3. Does the patient presented with shadow or curtain affecting any part of the vision, flashes, diminished vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Tractional retinal detachment documented on Fundus Examination, OCT and B scan: Yes/No (Upload Fundus sketch/ photograph AND OCT AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral Thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy + Membrane Peeling+ Endolaser the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

37. Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection (Maximum – 6): Macular edema d/t AMD, CRVO, BRVO, Diabetic proliferative vitreo-retinopathy, vitreous hemorrhage: S3B6.3

1. Name of the Procedure: Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection (Maximum – 6)

2. Select the Indication from the drop down of various indications provided under this head:

Macular edema d/t AMD, CRVO, BRVO, Diabetic proliferative vitreoretinopathy, vitreous hemorrhage
All types of Choroidal Neovascularization (CNV)

3. Does the patient presented with blurred or wavy central vision and/or colors appear "washed out" or changed: Yes/No

4. If the answer to question 3 is Yes is there evidence of Macular edema documented on Fundus Examination, FFA and OCT Macula: Yes/No (Upload Fundus sketch/ photograph AND FFA AND OCT Macula Report)

5. If the answer to question 4 is Yes is there evidence of allergy, cerebrovascular accident, fibrovascular disciform scar, pre-existing RD, RPE tears: Yes/No

For eligibility for Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

38. Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection (Maximum – 6): All types of Choroidal Neovascularization (CNV): S3B6.3

1. Name of the Procedure: Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection (Maximum – 6)

2. Select the Indication from the drop down of various indications provided under this head:

Macular edema d/t AMD, CRVO, BRVO, Diabetic proliferative vitreoretinopathy, vitreous hemorrhage
All types of Choroidal Neovascularization (CNV)

3. Does the patient presented with sudden deterioration of central vision, noticeable within a few weeks/ metamorphopsia/ colour disturbances: Yes/No

4. If the answer to question 3 is Yes is there evidence of Choroidal Neovascularization documented on Fundus Examination, FFA and OCT Macula: Yes/No (Upload Fundus sketch/ photograph AND FFA AND OCT Macula Report)

5. If the answer to question 4 is Yes is there evidence of allergy, cerebrovascular accident, fibrovascular disciform scar, pre-existing RD, RPE tears: Yes/No

For eligibility for Monthly Intravitreal Anti-VEGF for Macular Degeneration - Per Injection the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

39. Vitrectomy - Membrane Peeling Endolaser, Silicon Oil Or Gas: Vitreous hemorrhage with tractional R D: S3B6.4

1. Name of the Procedure: Vitrectomy - Membrane Peeling Endolaser, Silicon Oil Or Gas

2. Indication: Vitreous hemorrhage with tractional Retinal Detachment

3. Does the patient presented with visual haze/ floaters/ cloudy vision/ photophobia and perception of shadows and cobwebs with shadow or curtain affecting any part of vision: Yes/No

4. If the answer to question 3 is Yes is there evidence of Vitreous hemorrhage with tractional Retinal Detachment documented on Fundus Examination and B scan: Yes/No (Upload Fundus sketch/ photograph AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral thinning: Yes/No
   b. Panopthalmitis: Yes/No

For eligibility for Vitrectomy - Membrane Peeling Endolaser, Silicon Oil Or Gas the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

40. Removal Of Silicon Oil Or Gas: Previous retinal surgery like vitrectomy + silicon oil or gas: S3B6.5

1. Name of the Procedure: Removal Of Silicon Oil Or Gas

2. Indication: Previous retinal surgery like vitrectomy + silicon oil or gas

3. Does the patient underwent previous retinal surgery like vitrectomy + silicon oil or gas : Yes/No (Upload previous treatment notes)

4. If the answer to question 3 is Yes is there evidence of silicon oil or gas documented on Fundus Examination and B scan: Yes/No (Upload Fundus sketch/ photograph AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Prethisical eye: Yes/No
   b. Hypotony: Yes/No

For eligibility for Removal Of Silicon Oil Or Gas: Previous retinal surgery like vitrectomy + silicon oil or gas the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

41. Vitrectomy Plus Silicon Oil Or Gas: Tractional Retinal Detachment: S3B6.6

1. Name of the Procedure: Vitrectomy Plus Silicon Oil Or Gas

2. Select the Indication from the drop down of various indications provided under this head:

Tractional Retinal Detachment
Rhegmatogenous Retinal Detachment

3. Does the patient presented with shadow or curtain affecting any part of vision, flashes, diminished vision : Yes/No

4. If the answer to question 3 is Yes is there evidence of tractional retinal detachment documented on Fundus Examination and B scan: Yes/No (Upload Fundus sketch/ photograph AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral thinning: Yes/No
   b. Panophthalmitis: Yes/No

For eligibility for Vitrectomy Plus Silicon Oil Or Gas the answer to questions 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

42. Vitrectomy Plus Silicon Oil Or Gas: Rhegmatogenous Retinal Detachment: S3B6.6

1. Name of the Procedure: Vitrectomy Plus Silicon Oil Or Gas

2. Select the Indication from the drop down of various indications provided under this head:

Tractional Retinal Detachment
Rhegmatogenous Retinal Detachment

3. Does the patient presented with signs and symptoms suggestive of Rhegmatogenous retinal detachment : Yes/No

4. If the answer to question 3 is Yes is there evidence of Rhegmatogenous retinal detachment documented on Fundus Examination and B scan: Yes/No (Upload Fundus sketch/ photograph AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of:
   a. Scleral thinning: Yes/No
   b. Panophthalmitis: Yes/No

For eligibility for Vitrectomy Plus Silicon Oil Or Gas the answer to questions 5a AND 5b should be No

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NAME OF THE HOSPITAL: _____

43. Socket Reconstruction: Contracted socket not retaining prosthesis: S3B7.1

1. Name of the Procedure: Socket Reconstruction

2. Indication: Contracted socket not retaining prosthesis

3. Does the patient have history of evisceration done: Yes/No (Upload previous treatment/ operative notes)

4. If the answer to question 3 is Yes is there evidence of Contracted socket size not retaining prosthesis: Yes/No (Upload Clinical Photograph)

5. If the answer to question 4 is Yes is there evidence of Congenital contracted socket due to bone abnormality: Yes/No

For eligibility for Socket reconstruction the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

44. Dermis Fat Graft: Anophthalmia in children: S3B7.2

1. Name of the Procedure: Dermis Fat Graft

2. Select the Indication from the drop down of various indications provided under this head:

Anophthalmia in children
Deep superior sulcus deformity

3. Does the patient presented with signs of Anophthalmia: Yes/No (Upload Clinical Photograph)

For eligibility for Dermis fat graft the answer to question 3 should be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

45. Dermis Fat Graft: Deep superior sulcus deformity: S3B7.2

1. Name of the Procedure: Dermis Fat Graft

2. Select the Indication from the drop down of various indications provided under this head:

Anophthalmia in children
Deep superior sulcus deformity

3. Does the patient presented with signs of deep superior sulcus deformity: Yes/No (Upload Clinical Photograph)

For eligibility for Dermis fat graft the answer to question 3 should be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

Treating Doctor Signature with Stamp

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NAME OF THE HOSPITAL: _____

46. Orbitotomy: Orbital tumours or cysts: S3B7.3

1. Name of the Procedure: Orbitotomy

2. Select the Indication from the drop down of various indications provided under this head:

Orbital tumours or cysts
Orbital foreign body
Orbital wall fractures

3. Does the patient presented with signs and symptoms suggestive of Orbital tumours or cysts: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Orbital tumour or cyst documented on MRI Brain+Orbit and B scan: Yes/No (Upload MRI Brain+Orbit AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of
   a. tumours with extension in Brain: Yes/No
   b. small cysts < 3mm: Yes/No

For eligibility for Orbitotomy the answer to question 5a AND 5b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

47. Orbitotomy: Orbital foreign body: S3B7.3

1. Name of the Procedure: Orbitotomy

2. Select the Indication from the drop down of various indications provided under this head:

Orbital tumours or cysts
Orbital foreign body
Orbital wall fractures

3. Does the patient presented with history of trauma to eye with retained foreign body inside the orbit & outside the eyeball: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Orbital foreign body documented on CT Brain+Orbit and B scan: Yes/No (Upload CT Brain+Orbit AND B scan Report)

5. If the answer to question 4 is Yes is there evidence of tumours with extension in Brain: Yes/No

For eligibility for Orbitotomy the answer to question 5 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

48. Orbitotomy: Orbital wall fractures: S3B7.3

1. Name of the Procedure: Orbitotomy

2. Select the Indication from the drop down of various indications provided under this head:

Orbital tumours or cysts
Orbital foreign body
Orbital wall fractures

3. Does the patient presented with history of trauma to eye with associated pain and swelling of the area: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is the eyeball intact: Yes/No

5. If the answer to question 4 is Yes is there evidence of Orbital fracture documented on CT Brain+Orbit and B scan: Yes/No (Upload CT Brain+Orbit AND B scan Report)

6. If the answer to question 5 is Yes is there evidence of tumours with extension in Brain: Yes/No

For eligibility for Orbitotomy the answer to question 6 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

49. Enuleation With Orbital Implant: Intraocular malignancy not amenable to medical therapy: S3B7.4

1. Name of the Procedure: Enucleation with Orbital Implant

2. Select the Indication from the drop down of various indications provided under this head:

Intraocular malignancy not amenable to medical therapy
Painful Blind eye
Severely traumatized eye with other eye at risk of sympathetic ophthalmia

3. Does the patient presented with signs and symptoms suggestive of Intraocular malignancy: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Intraocular malignancy documented on CT Orbit and B scan: Yes/No (Upload CT Orbit AND B scan Report)

For eligibility for Enucleation with Orbital implant the answer to question 4 should be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

50. Enuleation With Orbital Implant: Painful blind eye: S3B7.4

1. Name of the Procedure: Enucleation with Orbital Implant

2. Select the Indication from the drop down of various indications provided under this head:

Intraocular malignancy not amenable to medical therapy
Painful Blind eye
Severely traumatized eye with other eye at risk of sympathetic ophthalmia

3. Does the patient presented with signs and symptoms suggestive of Painful blind eye: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Intraocular damage documented on CT Orbit and B scan: Yes/No (Upload CT Orbit AND B scan Report)

For eligibility for Enucleation with Orbital implant the answer to question 4 should be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

51. Enuleation With Orbital Implant: Severely traumatized eye with other eye at risk of sympathetic ophthalmia: S3B7.4

1. Name of the Procedure: Enucleation with Orbital Implant

2. Select the Indication from the drop down of various indications provided under this head:

Intraocular malignancy not amenable to medical therapy
Painful Blind eye
Severely traumatized eye with other eye at risk of sympathetic ophthalmia

3. Does the patient presented with signs and symptoms suggestive of Severely traumatized eye: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of Severely traumatized eye documented on CT Orbit and B scan: Yes/No (Upload CT Orbit AND B scan Report)

For eligibility for Enucleation with Orbital implant the answer to question 5 should be Yes

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

52. Rectus Muscle Surgery Single: To maintain binocular vision in children: S3B8.1

1. Name of the Procedure: Rectus Muscle Surgery Single

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision in children
Cosmesis

3. Does the patient presented with Squint associated with difficulty in binocular vision: Yes/No (Upload clinical Photograph)

4. If the answer to question 4 is Yes is there evidence:
   a. Pre-existing extra ocular muscle pathology: Yes/No
   b. Active thyroid ophthalmopathy: Yes/No

For eligibility for Rectus muscle surgery single the answer to questions 4a AND 4b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

53. Rectus Muscle Surgery Single: Cosmesis: S3B8.1

1. Name of the Procedure: Rectus Muscle Surgery Single

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision in children
Cosmesis

3. Does the patient presented with Squint affecting cosmetic appearance: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence:
   a. Pre-existing extra ocular muscle pathology: Yes/No
   b. Active thyroid ophthalmopathy: Yes/No

For eligibility for Rectus muscle surgery single the answer to questions 4a AND 4b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

54. Rectus Muscle Surgery Two/Three: To maintain binocular vision: S3B8.2

1. Name of the Procedure: Rectus Muscle Surgery Two/Three

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision
Poor vision and squint indicated for cosmetic purpose also

3. Does the patient presented with Squint associated with difficulty in binocular vision: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence active extra-ocular muscle pathology: Yes/No

For eligibility for Rectus muscle surgery two/three the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

55. Rectus Muscle Surgery Two/Three: Poor vision and squint indicated for cosmetic purpose also: S3B8.2

1. Name of the Procedure: Rectus Muscle Surgery Two/Three

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision
Poor vision and squint indicated for cosmetic purpose also

3. Does the patient presented with poor vision due to Squint/ squint affecting cosmetic appearance: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence active extra-ocular muscle pathology: Yes/No

For eligibility for Rectus muscle surgery two/three the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

56. Oblique Muscle: To maintain binocular vision when done in children: S3B8.3

1. Name of the Procedure: Oblique Muscle

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision when done in children
To correct double vision
Poor vision and cosmetic purpose

3. Does the patient presented with disturbing visual symptoms like diplopia and the resultant asthenopic symptoms due to squint: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of pre-existing extra-ocular muscle pathology: Yes/No

For eligibility for oblique muscle surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

57. Oblique Muscle: To correct double vision: S3B8.3

1. Name of the Procedure: Oblique Muscle

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision when done in children
To correct double vision
Poor vision and cosmetic purpose

3. Does the patient presented with disturbing visual symptoms like diplopia and the resultant asthenopic symptoms due to squint: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of pre-existing extra-ocular muscle pathology: Yes/No

For eligibility for oblique muscle surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

58. Oblique Muscle: Poor vision and cosmetic purpose: S3B8.3

1. Name of the Procedure: Oblique Muscle

2. Select the Indication from the drop down of various indications provided under this head:

To maintain binocular vision when done in children
To correct double vision
Poor vision and cosmetic purpose

3. Does the patient presented with poor vision due to squint/cosmetic purpose: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of pre-existing extra-ocular muscle pathology: Yes/No

For eligibility for oblique muscle surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

59. Lid Reconstruction surgery: Mutilating injuries of the eyelids: S3B9.1

1. Name of the Procedure: Lid Reconstruction Surgery

2. Select the Indication from the drop down of various indications provided under this head:

Mutilating injuries of the eyelids
Lid injuries resulting in corneal exposure
Neurological lesions/ trauma causing ptosis
Ectropion/entopion (with/without distichiasis)

3. Does the patient presented with signs and symptoms suggestive of mutilating injuries of the eyelids: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of
   a. significant systemic co-morbidity: Yes/No
   b. open globe injury: Yes/No

For eligibility for Lid reconstruction surgery the answer to question 4a AND 4b should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

60. Lid Reconstruction surgery: Lid injuries resulting in corneal exposure: S3B9.1

1. Name of the Procedure: Lid Reconstruction Surgery

2. Select the Indication from the drop down of various indications provided under this head:

Mutilating injuries of the eyelids
Lid injuries resulting in corneal exposure
Neurological lesions/ trauma causing ptosis
Ectropion/entopion (with/without distichiasis)

3. Does the patient presented with signs and symptoms suggestive of corneal exposure due to lid injury: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of significant systemic co-morbidity: Yes/No

For eligibility for Lid reconstruction surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

61. Lid Reconstruction surgery: Neurological lesions/ trauma causing ptosis: S3B9.1

1. Name of the Procedure: Lid Reconstruction Surgery

2. Select the Indication from the drop down of various indications provided under this head:

Mutilating injuries of the eyelids
Lid injuries resulting in corneal exposure
Neurological lesions/ trauma causing ptosis
Ectropion/entopion (with/without distichiasis)

3. Does the patient presented with ptosis due to neurological lesion/trauma: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of significant systemic co-morbidity: Yes/No

For eligibility for Lid reconstruction surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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NAME OF THE HOSPITAL: _____

62. Lid Reconstruction surgery: Ectropion/entropion (with/without distichiasis): S3B9.1

1. Name of the Procedure: Lid Reconstruction Surgery

2. Select the Indication from the drop down of various indications provided under this head:

Mutilating injuries of the eyelids
Lid injuries resulting in corneal exposure
Neurological lesions/ trauma causing ptosis
Ectropion/entropion (with/without distichiasis)

3. Does the patient presented with signs and symptoms of Ectropion/entropion: Yes/No (Upload clinical Photograph)

4. If the answer to question 3 is Yes is there evidence of significant systemic co-morbidity: Yes/No

For eligibility for Lid reconstruction surgery the answer to question 4 should be No

I hereby declare that the above furnished information is true to the best of my knowledge.

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